CHAPTER 4

THE PLANNED SYSTEM OF CARE FOR ADULTS

WHAT ARE THE MISSION AND VALUES FOR THE SYSTEM OF CARE FOR ADULTS?

The mental health constituency envisions a society in which adults with mental disabilities can develop the skills and acquire the supports and resources they need to succeed where they choose to live, learn and work; and to be responsible members of the community. This vision is best achieved through the development of a community-based system of care that empowers adults with mental disabilities to take an active role in their recovery. The purpose of creating a public mental health system that promotes recovery is to accomplish the following goals for adults:

- adults are healthy;
- adults live where they choose;
- adults engage in school, work, and other satisfying and productive daily activities;
- adults have adequate income;
- adults are safe and abide by the law; and
- adults have supportive relationships with others and meaningful connections to their communities.

The development of the community mental health system began with deinstitutionalization in the 1960's. The mental health system was faced with the fact that people with mental illness have residential, vocational, educational, and social needs and wants. In the 1970's, the community support system was developed to identify the essential components needed by a community to provide adequate services and support to persons with mental illnesses (National Institute of Mental Health, 1987, page 12). The community support system was defined as "a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Turner,). In the 1980's, the concept of psychiatric rehabilitation began to emerge. The rehabilitation model emphasized that mental illness not only causes mental impairments but also causes the person significant functional limitations. The rehabilitation model emphasized treating both the illness and its social consequences.

Recovery

California's mental health system is promoting recovery as a fundamental value for its adult system of care. The development of community support systems followed by the rehabilitation model with its more comprehensive understanding of the impact of severe mental illness laid the conceptual groundwork for service delivery programs and systems that promote recovery from mental illness (Stroul, 1989).

Recovery emphasizes a shift from a provider-based system of care to a system that values a network of support that is both provider-based and consumer-directed. Providers engage consumers to actively create and manage their own individual treatment plan rather than treating them as passive, dependent recipients of care. William Anthony, one of the first and foremost authors to write about recovery for persons with mental illness, provides the following description of recovery:

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993).

Mary Ellen Copeland, a recovering client and national leader in the recovery movement, emphasizes the importance of hope in recovery:

> We don't need dire predictions about the course of our symptoms – something that no one else, regardless of their credentials, can ever know. We need assistance, encouragement, and support as

> we work to relieve the symptoms and get on with our lives. We need a caring environment without feeling the need to be taken care of (Mead, 2000).

All participants in a consumer's recovery process work together with the understanding that recovery is always possible. For some individuals, recovery may be a longer, more gradual process. In order to support recovery, services must be continuously available and accessible as each individual's recovery indicates. Because each individual defines recovery differently, recovery occurs at different rates for each consumer. In addition, for many consumers, spirituality is a significant aspect of recovery and may be a critical element of well being.

The concept and experience of recovery may also be different for clients with different ethnic backgrounds. The mental health system must explore how a recovery vision can reflect the experience and values of the diverse ethnic groups in the State. In fact, the California Mental Health Directors Association makes the following statement in its Adult System of Care Framework:

> The cultural identities and worldviews of the consumers shape health and healing beliefs, practices, behaviors and expectations. Wellness is therefore, uniquely defined by each individual and each cultural group (California Mental Health Directors Association, 2000).

Current Treatment Models

The current trends in mental health service delivery include adult system-of-care models, such as assertive community treatment (ACT) and the integrated services agency (ISA). ACT and ISA models embrace the strategy of continuous community support services that facilitate a stable and satisfactory life and reduce the frequency, duration, and severity of relapse. In ACT and ISA models, all services to individuals are coordinated through an individual or team that functions as the single point of responsibility for all needs, helping individuals remain stable, increase functional capacity, and achieve a decent quality of life. These models should incorporate recovery concepts into their core values and programs. This blending of approaches, which requires a shift in the perspective of providers, professionals, clients, and family members, is already starting to occur. In fact, the California Mental Health Directors Association, working with representatives of the mental health constituency, is currently developing an adult system-of-care framework that embraces recovery-oriented services.

Recommendation: County mental health staff, provider organizations, consumers, and family members should be trained in the values and principles of recovery and should actively support recovery processes and the development of mental health services that enhance each consumer's recovery. Recovery-oriented treatment practices include the following:

- Each client has an achievable recovery potential;
- Outcome results reporting on a client's progress are immediately available at timely intervals;
- If clients do not make progress, the client collaborates with his or her provider to make creative changes to the client's individual treatment plan; and
- No client will be dismissed or considered a failure.

Recommendation: Consumer response to the Mental Health Statistics Improvement Project Consumer Survey, one of the outcome instruments for the adult system of care, should be monitored to assess the recovery orientation of mental health services.

WHAT ARE THE PRIORITY TARGET POPULATIONS IN THE SYSTEM OF CARE FOR ADULTS?

Statutory Definition

The impetus to develop California's adult target population definition began as a result of limited resources in the 1970's and 80's. County mental health departments had only a fixed amount of resources to provide to persons with mental illnesses. In most cases, this fixed amount was not sufficient to provide services to everyone that needed them. Counties were forced to prioritize service delivery so that only those clients whose symptoms were most severe were treated.

With the passage of the realignment legislation in 1991, the adult target population definition was put in statute. Welfare and Institutions Code (WIC) Section 5600.3 describes the target population for adults with mental

illness who are served by the public mental health system. That definition states that a client's mental illness must be severe in degree and persistent in duration, may cause behavioral functioning that interferes substantially with the primary activities of daily living, and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

Medi-Cal Managed Care Medical Necessity Definition for Recipients of Specialty Mental Health Services

With the consolidation of fee-for-service Medi-Cal mental health services and public Short-Doyle Medi-Cal mental health services, a "medical necessity definition" was developed to apply to both groups of Medi-Cal beneficiaries who now receive mental health services through the public mental health system.

Medical Necessity for Inpatient Mental Health Services

Section 1820.205 of the regulations governing the Medi-Cal inpatient mental health services defines medical necessity for inpatient services. A beneficiary must have a specified diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM IV) and require psychiatric inpatient hospital services as the result of a mental disorder, due to certain symptoms or behaviors.

Medical Necessity for Outpatient Mental Health Services

Section 1830.205 defines medical necessity for outpatient, or "specialty" mental health services. Beneficiaries must have a DSM IV diagnosis with a significant impairment related to the diagnosis or the probability of significant deterioration or lack of developmental progress. Eligible care for medically necessary services must be focused on the impairment; the client must be expected to benefit from the intervention; and the conditions should not be responsive to treatment that could be provided by the physical health care system.

Although a single standard of care in which only one target population definition is used would be most logical for persons who need mental health services, a lack of resources causes this dual system of care. Many clients are not eligible for Medi-Cal benefits. For these clients, counties must still prioritize services based on whether these clients meet the target population definition because the county must pay for services provided to these clients through limited public mental health dollars that are allocated from realignment funding.

WHAT SERVICES AND PROGRAMS SHOULD BE PROVIDED TO ADULTS WITH MENTAL DISABILITIES TO IMPROVE THEIR OUTCOMES?

Accountability in California's mental health system is accomplished in part through the use of performance outcome data. Chapter 7, System Accountability and Oversight, provides a detailed summary of how this system of accountability evolved and how the California Mental Health Planning Council (CMHPC) intends to use performance indicators for system oversight. Performance outcome indicators are intended to quantify for each county measurable changes in clients' lives to determine if mental health services are improving basic aspects of clients' quality of life.

Problem: Clients lack access to mental health services.

Access to mental health services is obviously a prerequisite for achieving positive outcomes for clients. Chapter 2 indicates that an overwhelming number of adults in need of public mental health services do not have access to them. Over the last few years, the Legislature has provided specific categorical augmentations that have improved access for some clients. However, the mental health system really needs a substantial general augmentation to its funding so that access is available for all clients who seek mental health services.

Recommendation: The Administration and the Legislature should appropriate additional funds for services for adults.

The following sections of this chapter are divided into six aspects of a client's life, which include health, living situation, productive daily activity, financial status, legal issues, and social support network. Each section describes problems and challenges clients face achieving positive outcomes in these domains, reviews proposals and pilot projects to address these problems, and makes recommendations for system change.

Health

Physical Healthcare

Problem: Clients' physical health problems often go undetected, untreated, or inappropriately diagnosed.

Many studies have shown a very high prevalence of serious physical illnesses in persons being treated for mental illness. These physical illnesses are often undetected or untreated because the client cannot effectively communicate the physical symptoms and physicians often attribute somatic symptoms to the mental illness. Kaplan states that anywhere from 24 to 60 percent of persons who have been identified in the target population have been shown to suffer from associated physical disorders (Kaplan, 1998, page 299). In 1985, in response to Chapter 208, Statutes of 1982 (SB 929), Koran studied the prevalence of undiagnosed and untreated physical diseases in clients under the care of county mental health systems in four California counties (Koran, 1985). The study revealed that 45 percent of the clients had acute physical diseases. Twenty-two percent had their disease detected at the time of intake into the mental health system, and 23 percent of the clients had diseases that remained undiagnosed.

Kaplan (1998) states, "Among the most inappropriately treated patients in the mental health system are those who have medical problems that either cause or contribute to their psychiatric symptoms. Study after study has shown that psychiatric patients have more medical problems than the average members of society and that the most severely psychotic in this population have the most serious and/or the greatest numbers of medical problems" (Kaplan, 1998, page 152).

With the advent of managed mental health care in the public sector, California's mental health system "carved out" its services into "specialty mental health" services, designed to serve Medi-Cal beneficiaries whose mental illnesses meet the medical necessity definition criteria. (See Chapter 6, Managed Mental Health Care, for more information on this system.) The county managed health care plans, which are responsible for providing physical health care to Medi-Cal recipients, and the county managed mental health plans have developed memoranda of understanding to coordinate care. This coordination includes providing clinical consultation and training, referral protocols, exchange of medical records information, and a process for resolving disputes between plans.

Egnew and Geary, describing the interface with health care in a carved-out mental health care system, report that the challenges include ensuring a timely process for referral, information sharing, and consultation and ensuring easy and timely access. They believe that "ensuring adequate access to both medical/surgical and behavioral healthcare is a critical public policy issue" (Egnew, 1996).

Primary care providers actually see a large percentage of clients with significant psychiatric diagnoses. The California Medical Association (CMA) estimates that about eighty percent of persons with mental illness are seen first by primary care physicians (California Medical Association,). Primary care physicians should be able to identify these illnesses accurately and make the appropriate diagnosis or refer clients to specialty mental health services. If mental illnesses are identified and treated in a timely manner, client outcomes are better and treatment is more cost-effective. In 1998, the California Medical Association adopted a resolution to collaborate with other organizations to provide mental health training for primary care physicians. (California Medical Association, 1998).

Although women utilize health services more than men do, they still face significant barriers, including lack of or inadequate health insurance coverage. Services to meet the needs of women who face trauma, severe depression, eating disorders, or other psychological disabilities are insufficient (California Institute for Mental Health, 1999).

Recommendation: Mental health clinicians should ensure that clients entering the mental health system receive thorough physical exams.

Recommendation: Mental health providers should encourage clients to use health care, especially education and prevention services, such as smoking cessation programs.

Co-Occurring Mental Illness and Drug and Alcohol Use

The Department of Mental Health (DMH) describes the problem of co-occurring mental health and alcohol and drug use as follows:

> Within the last decade it has become increasingly clear that substance abuse and mental illness when occurring simultaneously present a synergistic force which exacerbates both problems. Persons with a co-existing disorder are among the highest cost users within the publicly funded health care and criminal justice systems, and are a public safety concern when left untreated…(California Department of Mental Health, 1997b).

> It is estimated that approximately 60 percent of persons with Serious Mental Illness (SMI) also have a substance abuse problem and that up to 90 percent or more of the highest cost users of services and forensics consumers also abuse substances (California Department of Mental Health, 1997a, page 16).

The Program for Assertive Community Treatment (PACT) Model describes the challenges faced by clients with co-occurring mental illness and alcohol and drug use:

> Clients with dual diagnosis present a substantial treatment challenge to mental health systems. As compared with other clients, their functioning is poorer (e.g., increased symptoms and impairment, hospitalization, incarceration, homelessness, physical problems), and they are more difficult to treat and rehabilitate (e.g., less adherent with mental health and substance abuse treatment services, showing a greater complexity of problems and needs). (Allness, 1998, page 58).

Problem: Lack of integrated treatment programs for co-occurring mental health and alcohol and drug use.

Historically, treatment of mental illness and substance abuse has been addressed by separate programs typically under separate government departments or agencies. Basic treatment philosophies between the two systems differ substantially. Many substance abuse treatment programs require total abstinence from any substance, which poses a problem for mental health clients with substance abuse problems who must take medications to control their mental illnesses. The DMH states that, "It is imperative that attempts to address issues of dual diagnosis take place as an integrated and unified program. Integrated service delivery for both problems has been shown to be highly cost-effective" (California Department of Mental Health, 1997b).

In May 1995, the Department of Mental Health (DMH) and State Alcohol and Drug Programs (ADP) formed the Dual Diagnosis Task Force. The purpose of the Task Force is to support the development of and promote effective programs for clients with dual diagnosis, to foster cooperative efforts in the treatment of this group of clients at the local level, and to promote access to those treatment programs. The DMH and ADP awarded three million dollars over a three-year period in federal Substance Abuse and Mental Health Services Administration (SAMHSA) funds to four projects. Each project is designed to demonstrate the efficacy of integrated mental health and alcohol and other drug treatment/recovery programs for persons with a dual diagnosis in a county system of care. Following the conclusion of the projects in 2000, they will be independently evaluated to provide data on the effectiveness of integrated treatment, clinical outcomes, consumer satisfaction, client quality of life, costs, and cost savings or avoidance in the area of physical health care and criminal justice.

Recommendation: If the dual diagnosis pilot projects prove to be effective, the DMH and ADP should seek funding to expand integrated treatment programs for clients with dual diagnosis by offering incentives or matching funds to counties that replicate these models.

Living Situation

Problem: Housing shortages and homelessness.

The DMH reports that approximately "seven percent of the adult population in the United States, or about 12 million Americans, have been homeless at least once in their lives. More than three-quarters of homeless single adults have persistent mental or physical illnesses or substance abuse problems. In California, at least 150,000 people are homeless, and studies indicate that at least half are disabled with mental illness, medical problems, or other health conditions" (California Department of Mental Health, 1998a).

A report prepared by the State Independent Living Council in April 1999 states that "Housing affordability is a major problem in California…There is a severe scarcity of low-income housing in communities throughout California, notably in major metropolitan areas. Individuals who rely exclusively on Social Security Income (SSI) cannot pay the prevailing or market rental rate for any type of decent apartment or house…Given the lack of low-income, accessible housing, increasing numbers of people with disabilities are forced to choose between restrictive congregate settings and homelessness" (Tootelian, 1999). In California, Social Security Income/State Supplemental Program (SSI/SSP) is only $692.00 per month for most clients. This amount is insufficient in many counties. In fact, at the June 2000 CMHPC meeting, a client recently testified that in San Mateo County clients are living with four or more clients in a small two-bedroom apartment and giving up half or more of their SSI/SSP check for rent. The rest of the money goes to buy the food and other necessities they will need for the month.

Persons with mental illnesses face multiple barriers to finding and maintaining safe, affordable housing. Besides lacking adequate income, many people have co-occurring disorders, including alcohol and other drug problems and acute or chronic physical health problems. They also face stigma associated with their illnesses and the fears of potential landlords or neighbors. Women who are homeless and mentally ill face additional gender/role barriers. They are more vulnerable to sexual trauma and violence. Some women are reluctant to access housing services for fear that their children may be taken away from them. Often, housing programs have rigid guidelines for women using the facilities. Women may not be able to comply with the rules if they have children in their care or other problems.

Persons with mental illnesses need the support of community mental health services to be able to maintain housing in the community. In the past, the concept of transitional housing was thought to be most effective for people moving toward independent living. However, research and practical experience have found that, although persons with mental illnesses have varying needs for support at different times in their illnesses, their housing does not necessarily have to change as those needs change. In fact, forcing an individual to move just when he or she has achieved some level of comfort and competence in a particular living situation may be detrimental. Housing arrangements should be permanent with flexible supports provided onsite or offsite for as long as the individual needs or desires them.

Although many clients want to live independently, some clients may have different goals due to cultural and ethnic differences. The mental health system needs to take into account how such differences might influence a client's preferred living arrangement. Housing should be culturally congruent. Independent housing may not be the ultimate goal of clients from different cultural backgrounds. For example, in some Asian cultures, young women are expected to live with their families until they get married. In some Latino families, reunification with the family may be the goal.

Federal and State Efforts to Provide Housing

The DMH has received federal homeless funds through the Stewart B. McKinney Homeless Block Grant since 1985. Beginning in 1991, the funding came through the McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant. Each county with PATH programs has established one or more programs of outreach or services to persons who are homeless and have a mental illness.

In State Fiscal Year 1998-1999, the DMH assumed an active role in the development of supportive housing for persons with a serious mental illness who are homeless or at risk of homelessness. The DMH redirected increases from the PATH and Substance Abuse and Mental Health Services Administration (SAMHSA) programs to initiate a competitive grant process that resulted in mental health funding of 13 supportive housing demonstration projects in both rural and urban counties.

Additionally, pursuant to the California Supportive Housing Initiative Act (SHIA, Chapter 310, Statutes of 1998) the DMH became the lead agency in administering supportive housing grants for low income persons with serious mental illness and/or other special needs populations. This legislation also established the Supportive Housing Program Council, which is comprised of representatives from multiple state agencies who provide recommendations and support to the DMH in administering this grant program. Under the SHIA program, six supportive housing projects were funded in SFY1999-2000 and five have been funded this year. The Budget Act for Fiscal Year 2000-2001 have provided an additional $25 million for additional new projects.

Recommendation: The DMH should continue its efforts in the statewide expansion and development of new supportive housing grants through both state and federal funding.

Recommendation: The DMH should encourage housing programs to reduce restrictions that present barriers to women with mental illness, including women with children. Programs should engage in outreach to women with mental illness, offer community support tailored to their needs as caregivers, and be flexible in their requirements so that they do not preclude serving women with children.

Productive Daily Activity

Productive daily activity includes engaging in meaningful daily activities, including education and training, volunteer activity, and competitive employment.

Education Supports and Reasonable Educational Accommodations

New opportunities to obtain a college education have opened up for mental health as Jackie Groshart, Psychological Disabilities Specialist, explains:

> Individuals with major mental illness often experience their first symptoms at the age when they would typically be entering college. In the past, depending on the severity of the symptoms, they have either been unable to pursue their education or have been severely limited in this area. Today with the advent of extremely effective medication and adjunct therapy to control symptoms, and the passage of legislation which ensures the right to accommodations, an increasing number of these students are able to attend school successfully (Groshart, 1997).

Educational accommodations and auxiliary aids that help to level the playing field for persons with disabilities in higher education must also be provided to qualified students with psychiatric disabilities. In addition to mandated accommodations, postsecondary education institutions provide varying degrees of educational support services depending on the segment, the individual campus, and whether funding is private or public.

Reasonable accommodations and support services encourage individuals with mental disabilities to enter or reenter adult, postsecondary, and technical education institutions. Examples of reasonable accommodations include assistance with registration; testing accommodations (extended time or taking tests alone with a proctor) to alleviate difficulty during timed tests; tape recorders in class to remedy easy distractibility; note takers to compensate for poor concentration; access to special parking; and seating arrangement modifications. Examples of supports include access to campus counselors trained in psychiatric disabilities, peer supports, advocacy skills training, access to special classes such as stress management and memory enhancement, assistance accessing campus services and resources such as financial aid, and assistance with retention-related problems while hospitalized.

Access to reasonable accommodations and related services for students with mental disabilities can help them be successful in higher education. Campus counselors must have a combination of counseling skills, a supportive and nonjudgmental attitude, and the knowledge of disability issues (Groshart, 1997) but do not necessarily need to be specialists in psychiatric disabilities (Parten, in press). Some postsecondary institutions provide specialized counselors for students with mental disabilities; a few community colleges offer specialized programs. However, 2- and 4-year college counselors for students with disabilities are, for the most part, generalists, while adult education entities may be unaware of the needs of this population. Adult and higher education entities that have access to a wide range of counselors, services, and relevant curricula are able to successfully accommodate, serve, and support a wider range of students with mental disabilities (Parten, in press).

Recommendation: County mental health departments should train staff in education accommodations and documentation of a disability-related educational limitation; initiate education supports in collaboration with adult, technical, and postsecondary education entities; and expand existing on-campus and off-campus supported education programs.

Recommendation: Clients' interest in pursuing adult or postsecondary education or technical training should be assessed. Clients should be informed of their legal right to accommodations in higher education settings and of the specific accommodations, services, supports, and resources available. Clients should also be informed that postsecondary education institutions are not required to provide services beyond academic accommodations; individual campuses may choose to provide enhanced services, but are not required to do so.

Recommendation: County mental health departments should advocate for more funding, training, and education of adult and postsecondary education counselors who are specifically assigned to students with mental disabilities.

Supported Employment

The Report of the Surgeon General states that people with severe mental illnesses tend to be poor (U.S. Department of Health and Human Services, 1999). Although the reasons are not understood, poverty is a risk factor for some mental disorders as well as a predictor of poor long-term outcome among people already diagnosed. People with serious mental illnesses often become dependent on public assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disabilities is approximately 90 percent. Women with mental disabilities have a lower employment rate than men with mental disabilities

and appear to underserved by rehabilitation services. Only 40 percent of people with mental illness who receive rehabilitation services are women (California Institute for Mental Health, 1999).

Problem: Lack of employment that provides flexibility for persons with mental illness.

The Surgeon General's Report also observes that an adequate standard of living and employment are associated with better clinical outcomes and quality of life. Although newer vocational rehabilitation and employment initiatives strive to remedy persistently high levels of unemployment, most consumers find themselves unable to work consistently or at all. This problem results from active symptoms, profound interruptions of education and employment caused by symptom onset and exacerbation, stigma and discrimination, lack of higher education programs, and being limited to low-paying menial jobs.

According to the National Association of State Mental Health Program Directors (NASMHPD),

> The lack of jobs that provide flexibility for adults with serious mental illness is a major barrier to successful community living, a personal loss to people who wish to work, a societal loss to employers and taxpayers, and a barrier to successful recovery for those with mental illness.
>
> Chronic unemployment can lead to isolation, poverty, and a diminishing self-worth in any adult, hindering efforts at recovery. In addition, one residual effect of chronic unemployment for persons with psychiatric disabilities is the perpetuation of homelessness. The current high rate of unemployment among people with psychiatric disabilities – estimated at 85 percent – must be lowered. The focus should not only be on employment opportunities, but also on habilitation and rehabilitation, including integrated supported competitive employment to better enable individuals with mental illness to participate in the workforce (National Association of State Mental Health Program Directors, 2000).

Employment that is competitive, integrated, paid, and meaningful is of fundamental importance to the quality of life for persons with mental disabilities. The NASMHPD position statement on employment and rehabilitation makes the following points:

- State mental health authorities should assume a leadership role in significantly increasing the rate of employment among individuals with psychiatric disabilities.
- Vocational rehabilitation agencies and state mental health authorities should collaborate and design program linkages and develop a range of employment options to increase rehabilitation opportunities to individuals requiring mental health services.
- Mental health policymakers should work to maximize the availability of community supports and case management efforts that focus on employment issues early in the rehabilitation process.
- Employment support and rehabilitation standards must be flexible to accommodate the episodic nature of mental illnesses.
- Effective rehabilitation services must view successful rehabilitation for individuals with mental illness differently than for others, adapting to the needs of all individuals with psychiatric disabilities.
- Employment support must be an integral component of comprehensive community support programs (National Association of State Mental Health Program Directors, 2000).

Recommendation: County mental health departments should initiate new supported employment programs and expand existing programs for persons with mental disabilities.

Department of Mental Health/Department of Rehabilitation Cooperative Programs

County mental health departments and the California Department of Rehabilitation (DR) have joined together to provide an array of cooperative services throughout the State. These programs have been built with consumer and family member participation. They embrace the values of comprehensive service linkages; consumer career choice; placement in a competitive, integrated environment; reasonable accommodations; and ongoing support. Currently, 27 cooperative agreements exist. In addition, the DMH and the DR have an interagency agreement to provide coordinated vocational services for clients as they transition from state hospitals to local communities. Mental health professionals involved in these cooperatives continue to work with rehabilitation counselors through continuing education to identify the unique needs of persons with psychiatric disabilities.

Recommendation: The DMH/DR Cooperative model should be expanded to every county in California.

Recommendation: The DMH and DR should continue to provide staff with cross training about the needs of persons with mental disabilities.

Financial Status

Problem: Public assistance is not enough for clients to be able to afford anything other than the bare essentials.

Persons with mental illness should have an adequate income. According to the Department of Health and Human Services, "people with serious mental illnesses often become dependent on public assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disorders hovers at 90 percent. Consequently, they must rely on government disability-income programs, rent subsidies, and informal sources of economic support. Clients usually face such modest monthly budgets that there is no room for error. Funds are frequently depleted before the end of the month. (U.S. Department of Health and Human Services, 1999).

Recommendation: The CMHPC should facilitate a coordinated advocacy campaign at both the federal and state level to increase income supports for persons with mental illness.

Problem: People have a disincentive or are afraid to work because they could lose their SSI/SSP or other benefits, such as Medi-Cal.

Being able to work does not preclude the need for long-term services and supports, such as counseling and medication. "Those who work part time, and even many with full-time jobs, may not be able to obtain adequate insurance through their employers to cover their ongoing medical needs. In addition, because of the long-term and fluctuating nature of some mental illnesses, people with psychiatric disabilities may continue to go through periods when they are unable to work, thus requiring the continuation of medical and other benefits" (U.S. Department of Health and Human Services, 1999).

The National Council on Disability points out that a significant barrier to work is the possibility of losing benefits. "Many people with mental disabilities fear that if they work, the Social Security Administration (SSA) will declare them no longer disabled and therefore ineligible for further benefits, even though they have had no medical improvement. Because the probability of a recurrence is high, they are afraid to take the risk" (National Council on Disability, 1997)

The National Alliance for the Mentally Ill (NAMI) has advocated at the federal level for flexibility in the Medicaid law to allow people with mental illness to remain working while accessing health benefits:

> People with severe mental illnesses and other disabilities should not be forced into (and stay in) poverty in order to access Medicare or Medicaid. At the same time, these programs need to remain in place as federal entitlements in order to ensure that persons whose symptoms or impairments are so severe that they cannot work are not at risk for losing cash benefits or health coverage (National Alliance for the Mentally Ill, 2000).

In 1999 the "Ticket to Work and Work Incentives Improvement Act" (PL 106-170) made improvements in disability programs, allowing social security disability income (SSDI) and supplemental security income (SSI) beneficiaries to work to the greatest extent of their abilities. This Act shifted the philosophy behind the nation's public disability programs, including SSI, SSDI, Medicaid, and Medicare, to programs that foster work, independence, and self-sufficiency for people with mental illnesses.

PL 106-170 allows States to offer Medicaid coverage to SSI beneficiaries who go to work and allows a Medicaid buy-in for people with disabilities who earn more than 250 percent of the poverty level. California enacted Chapter 820, Statutes of 1999, which implemented this provision. Any employed person whose income does not exceed 250 percent of the federal poverty level and who is disabled for specified purposes is eligible for Medi-Cal benefits, subject to a sliding scale.

Recommendation: Providers, clients, and families should be educated about the reporting requirements if a client returns to work while in receipt of SSI or SSDI and the provisions that may be available to extend a client's benefits upon return to work or to reinstate benefits should the client be unable to continue working.

Legal Issues

Problem: Increased numbers of persons with mental illness who are involved with the criminal justice system.

Factors contributing to the increase in persons with mental illness who are involved with the criminal justice system can be traced back to the deinstitutionalization process of the 1960's as Izumi, Schiller, and Hayward explain:

> The expectation was that those persons not treated in the state hospitals would instead be treated in community settings. Unfortunately, reality did not live up to the plans of advocates and policymakers, and the mentally ill who previously would have been sent to state hospitals were instead often asked to fend for themselves, either on the streets or in the nominal care of relatives. Placed in this situation, the poor judgement, lack of control, and deteriorating living conditions of the mentally ill resulted, not surprisingly, in increased arrest rates... (Izumi, 1996).

Now 30 years later, community mental health resources are still inadequate. The mental health system is so overburdened that only those persons with the most serious mental illnesses are served. Chapter 2, Unmet Need for Public Mental Health Services, indicates that public mental health only serves approximately half of the total population in need of services. In many cases, the system does not have enough resources to use for anything other than acute hospitalization, which is the most costly, high-end intervention.

In 1993, the Los Angeles Board of Supervisors established a Task Force on the Incarcerated Mentally Ill. The Task Force studied the increasingly high rate of incarceration of persons with severe mental illness and provided recommendations. The Task Force stated:

> …it is clear that decreasing mental health resources and community support systems, increasing involvement of law enforcement officers with persons diagnosed with mental illness, insufficient intradepartmental and interagency collaboration, and very importantly, societal conditions disproportionately affecting persons with mental illness have resulted, at times, in the unnecessary criminalization of the target populations (Los Angeles County Task Force on the Incarcerated Mentally Ill, 1993, page 18).

Chapter 617, Statutes of 1999 (AB 34) was enacted to provide outreach to adults with mental illness who are at risk of being homeless, who are homeless, or who frequently enter the criminal justice system. The goal of these programs is for communities to provide outreach, mental health care, and follow-up services for the homeless, including housing and employment assistance. Initially, funding was provided to three demonstration projects to determine the effectiveness of these programs. The success of these programs paved the way for increased funding, which was increased in the Budget for Fiscal Year 2000-2001 to total approximately $55 million. Chapter 518, Statutes of 2000 added additional language that allowed for expansions of the existing programs and permitted additional counties to participate in these programs. Currently, 26 counties have been funded including the three initial pilot programs.

Recommendation: The State should fully fund programs that prove to be successful in providing outreach, mental health care, and follow-up services, such as the programs established by Chapter 617, Statutes of 1999 (AB 34).

Problem: Lack of law enforcement training, diversion programs, and discharge planning to treatment programs.

Mentally ill offenders (MIOs) are persons with mental illness who commit a crime and enter the criminal justice system. These people may become involved with the criminal justice system because of a lack of services, homelessness, or substance abuse. Many are detained or arrested for a variety of petty crimes, such as shoplifting or creating a public nuisance. Some may be detained for crimes that are more serious. Often, law enforcement officers will detain these persons in order to divert them into the mental health system rather than arresting them with a misdemeanor such as disturbing the peace, trespassing, and vandalism. However, with the limited availability of mental health resources, law enforcement officers are frequently unable to find alternatives to incarceration.

The Los Angeles Task Force on the Incarcerated Mentally Ill also found that "there are some persons that require secure correctional detention and who should receive appropriate mental health services within the jail. It is imperative, however, to develop cost effective and humane strategies for diversion of minor offenders to

mental health settings and to provide them with the necessary community support systems, including housing, to prevent recidivism." (Los Angeles County Task Force on the Incarcerated Mentally Ill, 1993, page 18).

Pre-Booking Interventions

Pre-booking interventions usually occur at the scene of an incident. Pre-booking interventions require that police officers be trained in crisis intervention. Some counties have developed accredited training through Peace Officers Standards and Training (POST). In Monterey and Santa Clara counties, this 40 hour training course teaches law enforcement officers to make appropriate decisions when confronting a person with mental illness who is in crisis or who is acting dangerously without having to resort to force. In addition, non-uniformed mental health professionals may be employed by or under contract to local law enforcement agencies to assist patrol officers to respond to incidents. Mobile community mental health center employees may respond to such incidents as part of a team with police. Mental health staff based at community mental health centers cooperate with police in responding to such incidents.

Post-Booking or Pre-Adjudication Diversion

Post-booking or pre-adjudication interventions take place once a person has been arrested or incarcerated. These diversion programs usually require an offender to comply with a plan in order to be released. A public defender, court officials, and mental health officials may develop a release plan and present it to the judge at the initial court hearing. The judge may withhold final disposition of the case for a period of time to ensure the client's compliance with the release plan.

Recommendation: Counties should advocate for all law enforcement officers to attend the POST-accredited 40-hour training course on mental health.

Recommendation: The DMH and other appropriate state entities should develop and provide grants to counties to implement diversion program pilot projects.

Problem: Lack of appropriate care of mentally ill offenders in jails.

The jail environment is not conducive to helping a person with mental illness. The local jail frequently does not have adequate staffing to provide the screening needed to identify offenders with mental illness. The jails are overcrowded, often exacerbating the problems being experienced by the mentally ill offender. Jail staff frequently lack training in dealing with persons with mental illness. During the booking process, most jail settings do not provide enough crisis management. The number of mental health staff in the jails is insufficient to provide mental health services; staff can only triage the most serious cases and dispense psychotropic medications. Many inmates are released before their request for mental health care can even be met. Release planning is insufficient. Mentally offenders are often released unsupported into the community only to reoffend. Jail is meant to punish or control and is not meant for the care of a person with serious mental illness.

Another major problem for mentally ill offenders is that the prescription drug formulary for jail medical services is outdated and does not include the newer psychotropic medications. A change in medication can cause further destabilization and impede any progress that has been made if an offender was being treated with the newer psychotropic medications.

Recommendation: Counties should implement the following recommendations to improve the quality of mental health services in their jails:

- The local law enforcement agency should routinely screen all incoming detainees for mental illness.
- Inmates with mental illness should be consolidated into a dedicated mental health housing unit.
- Extensive screening of detainees in jail should be performed to engage the consumer in the jail setting and seamlessly move them into the community.
- Additional positions should be provided in jail to enable jail mental health staff to respond to requests for mental health services, provide mental health interventions, and participate more fully in release planning.
- The jail medical formulary should include all of the latest psychotropic medications in order to ensure consistency with what the client is already taking and to ensure compliance.

DRAFT

Mentally Ill Offender Crime Reduction Program

Chapter 501, Statutes of 1998 (SB 1485) established the Mentally Ill Offender Crime Reduction (MIOCR) program through the Board of Corrections. This program provides four-year grants to county sheriffs to help support mentally ill offenders during incarceration and provide appropriate support for these offenders upon release. These programs also are helping to build relationships between law enforcement and mental health by providing community mental health services to people who would otherwise be released from jail with no mental health support and who would be likely to be re-arrested shortly thereafter.

The Budget Act for Fiscal Year 2000-2001 provides approximately $50 million to the Board of Corrections for this program, bringing the total amount of funding to $100 million, which is the total amount of funding requests submitted by counties in 1999.

Recommendation: If the MIOCR programs are proven effective, the State should fund these projects in any remaining county that does not have a program.

Problem: Limitations of the Local Court Systems

Most local court systems have limitations in their dealings with mentally ill offenders. Judges are often at a loss as to appropriate sanctions and punishment, and community treatment options are few or unavailable. A lack of coordination is evident when an inmate is released. For example, family members and community-based service providers are not informed of the date and time of a court hearing for a client they had supported or housed prior to incarceration. Many times, the judge will order an inmate's immediate release, which can take place in the early morning hours, without notifying anyone about the release.

Recommendation: Court officials should receive training to help identify, understand, and deal with persons with mental illness and with persons who have a mental illness and co-occurring mental illness and substance abuse disorder.

Recommendation: All counties should establish an Interagency Policy Council, which includes the Mental Health Department, Alcohol and Drug Department, Sheriff's Department, Police Department, Probation Department, Superior Court, District Attorney, Public Defender, Housing Authority, Department of Social Services, Department of Health Services, Parole Department, and the Rehabilitation Department. The duties of this council would be to coordinate discharge planning, provide consistent treatment of clients in jails, and to implement and expand diversion programs.

Problem: Persons with mental illness are stereotyped by the public as being violent.

A recent study on violence and mental disability found that almost two-thirds of the public say they believe persons with schizophrenia are prone to violence against others (Monahan,). In many cases, people who have psychiatric diagnoses are being scapegoated for society's violence when, in fact, these people are more likely to be victims of crime or suicide. In actuality, persons with mental illnesses account for a very small percentage of the violence in American society. "The prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse" (Monahan, 1998). In fact, the study concluded that only 3 percent of violence in American society comes from persons with mental illnesses.

The public's perception that persons with mental illness are violent is exacerbated by the increasing number of persons with mental illness who are involved with the criminal justice system. In addition, some advocates believe that the association of violence with mental illness is being actively promoted publicly, playing off people's fears for public protection in order to increase resources and funding for the mental health system.

Recommendation: The Legislature and the DMH should implement a campaign to help educate the public about the misperception of the relationship between violence and mental illness.

Social Support Network

A program description from the Long Beach Village Integrated Services Agency, entitled "The Village Concept," observes that the needs of persons with mental illness for social support are no different from those of most people. After the basic needs of food, shelter, and clothing are met, the need for friendship and social interaction become apparent. When sufficient opportunity is provided to meet these needs, the individual has a

sense of being embedded in a larger community. The individual develops a sense of dignity, self-worth, and belonging by having a definite role to play and a place in which to be and to grow.

Socializing and recreation teaches people social skills, provides them with leisure-time activities, and offers them involvement in community activities. Holshuh makes the following observation about how mental illness interferes with these natural processes:

> For persons with severe and persistent mental illnesses, onset of mental illness, acute episodes of symptoms, hospitalizations, and ongoing impairments have interfered with social development – forming relationships, making friends, getting married, getting and giving emotional support, and relating as adults with their families, employers, and landlords. In addition, these clients are a vulnerable group in need of but often lacking social support systems (Holshuh, 1992).

Consumer-Operated Service Programs

The self-help movement grew out of the idea that individuals who have experienced similar problems, life situations, or crises can effectively provide support to one another. Consumer-operated service programs offer support based on first-hand experiences with issues such as medication, social security and other income supports, housing, employment, human service agencies, families, and friends. These groups are formed by peers. They offer emotional support, friendship, individual advocacy, information about mental health issues, and a way to improve the mental health system.

> Consumer-operated programs include drop-in centers, case management programs, outreach programs, businesses, employment and housing programs, and crisis services, among others. Consumer staff are thought to gain meaningful work, to serve as role models for clients, and to enhance the sensitivity of the service system to the needs of people with mental disorders (Long, 1988).

Family Self-help

Problem: Lack of respite services for family members of persons with mental disabilities.

Family members of persons with mental disabilities also need support and respite services. They are under a great deal of stress caring for and obtaining resources for their family members who are mentally ill. Family members also feel stigmatized by society's attitude toward their family member's illness. Support organizations, such as NAMI California, help family members cope with the added stress and find available resources. In addition, family self-help groups result in better communication and interaction among family members.

In 2000 the Joint Committee on Mental health Reform (JCMHR) held a series of public hearings throughout the State to gather information and make recommendations about the mental health system. These hearings revealed that respite care is one of the highest unmet needs of family members who care for children and adults with serious mental illness. Lack of respite services results in caregiver "burnout."

Recommendation: The mental health system should provide respite services to family members of persons with mental disabilities.

Community Involvement

Problem: Lack of involvement and partnership by clients and family members in the mental health system.

During the Joint Committee on Mental Health Reform (JCMHR) hearings, a recurrent theme kept surfacing that clients and family members felt a lack of respect and partnership in the mental health system as well as a lack of access and a meaningful role in system design and implementation. The JCMHR also heard repeatedly from clients and families who had benefited through peer support activities, including self-help programs and family support programs. Through the support of family and peers, clients begin to become more involved in their community. Many clients have become community activists, helping other clients to navigate the human services system in their community.

Clients are becoming a political force. Campaigns to register to vote are underway as well as voter education to enable clients to vote for the candidates and measures that will benefit their lives the most. Clients are also

volunteering in their communities for a variety of service-oriented tasks. Becoming involved in the community makes recovery a tangible goal.

Recommendation: The DMH and local mental health programs should provide training and resources to help clients and their families have meaningful involvement in the design and implementation of mental health programs.

CONCLUSION

The system of care for adults in the public mental health system should be recovery-oriented, empowering clients to develop the skills and acquire the supports and resources they need to succeed where they choose to live, learn, and work. The public mental health system should support, to the greatest extent possible, the six aspects of a client's life, which include health, living situation, productive daily activity, financial status, legal issues, and social support network. The recommendations made in this chapter relate directly to these areas of a client's life and will support clients in their treatment and recovery.